

**MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION**

| | | |
|----------------------|---|--|
| HEALTH CARE PROVIDER |) | |
| |) | IN RE: Medical Fee Dispute No: _____ |
| |) | |
| vs. |) | Employee (Patient): _____ |
| |) | |
| EMPLOYER |) | Employee (Patient) Social Security No: _____ |
| |) | |
| |) | Date of Accident/Incident: _____ |
| |) | |
| INSURER |) | Workers' Comp Injury No: _____ |

APPLICATION FOR MEDICAL FEE DISPUTE PROCEEDING

The undersigned party or parties hereby make(s) application to the Division of Workers' Compensation of the State of Missouri for:

- ☐ evidentiary hearing
☐ administrative ruling

(Identify the type of proceeding being requested. In a request for an administrative ruling both parties must agree to the request and sign the application. The case will be submitted with supporting documentation and decided without an evidentiary proceeding. Supporting documentation must be attached.)

Health Care Provider

Employer/Insurer

Health Care Provider's Attorney (If applicable)

Employer's/Insurer's Attorney

Address and Telephone

Address and Telephone

Date: _____

Date: _____

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the Application for Medical Fee Dispute Proceeding has been mailed by first-class mail, postage prepaid or hand delivered to _____
(name and address of opposing party or opposing party's attorney)

this _____ day of _____, 20____.

Affiant